STATE OF TENNESSEE
DEPARTMENT OF HEALTH
FAMILY HEALTH AND WELLNESS
NEWBORN SCREENING PROGRAM
710 James Robertson Parkway, 8th Floor
Nashville, TN 37243
Phone (615) 532-8462 Fax (615) 532-8555

NEWBORN SCREENING REFUSAL FORM

Baby's Name:_____

Baby's Date of Birth:_____

Hospital of Birth:_____

Mother's Name:_____

Mark screens that will not be completed:

☐ **Blood Specimen Screen** ☐ **Hearing Screen** ☐ **Critical Congenital Heart Disease Screen**

I, _____, have been informed of the need for a newborn hearing screen, a pulse oximetry screen to detect critical congenital heart disease, and a blood test to screen for metabolic/genetic disorders as designated by the Department of Health.

I have been informed state law requires these tests and that violation of the blood test is a misdemeanor.

Nonetheless, I refuse this test at this time for my newborn baby, _____ because such tests conflict with my religious tenets and practices.

Under penalty of perjury pursuant to T.C.A. 68-5-403, I affirm such refusal because of a conflict with my religious tenets and practices.

Parent Signature:_____ Date:_____/_____/_____

Witness Signature:_____ Date:_____/_____/_____

This form shall be retained in medical record for the period of time defined by the hospital or provider policy.

Please fax this form to (615) 532-8555